

Minnesota Board of Nursing

For Your Information



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President's Message: Deb Haagenson, RN



On May 4, 2015, the National Council of State Boards of Nursing (NCSBN) special Delegate Assembly adopted a new Nurse Licensure Compact. A Nurse Licensure Compact (NLC)

for RNs and LPNs has been in place since 1997. The NLC, when adopted by state legislatures, allows mutual recognition of a nursing license between other NLC member states. Nurses who reside in and are licensed in a compact state are able to practice in other compact states.

The new NLC includes standards and more stringent eligibility requirements for RNs and LPNs seeking to obtain and maintaining multi-state privilege to practice. This addresses long-standing concerns that the licensure requirements vary from state to state. While states will still establish requirements for single-state practice, the requirements for multi-state practice will be standard across states. Some of the eligibility requirements of note for multi-state practice include:

- Meets home state's qualifications of licensure (or renewal).
- Holds an active, unencumbered license.
- Has submitted fingerprint or other biometric data for purposes of obtaining a criminal background check.

- Has not been convicted or found guilty of a felony offense.
- Has not been convicted or found guilty of a misdemeanor offense related to the practice of nursing.
- Is not currently enrolled in an alternative to discipline program.
- Is subject to self-disclosure requirements regarding current participation in an alternative program.
- Has a valid US Social Security number.

Because the above eligibility requirements are specific to a multi-state privilege to practice, nurses who do not meet the above requirements may still be granted a single-state license to practice, at the discretion of their home state Board of Nursing.

The NCSBN special Delegate Assembly also adopted an APRN compact on May 4. This compact supports multi-state practice for advanced practice nurses. The APRN compact is modeled after the NLC for RNs and LPNs, including the same stringent, standard eligibility requirements for multi-state practice by clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives and nurse practitioners.

The adoption of the new NLC and the APRN Compact recognizes the importance of facilitating interstate practice and supports increased access to safe nursing care for patients. Adoption of the new NLC and the

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Ten Years After the IOM Recommendation to NCSBN: Highlights of the Findings from the NCSBN National Nursing Adverse Event Reporting System - TERCAP®

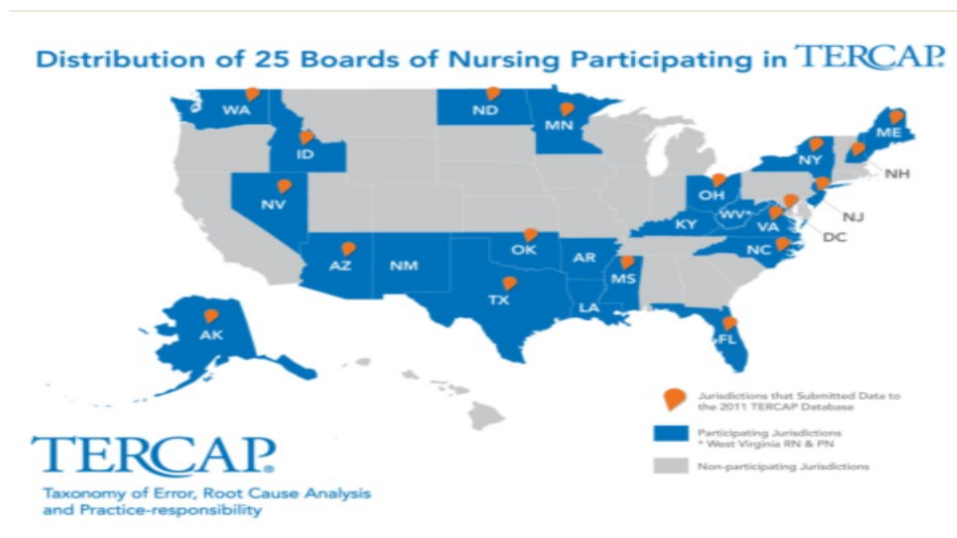
A decade has passed since the publication of the 2004 Institute of Medicine (IOM) report “Keeping Patients Safe: Transforming the Work Environment of Nurses,” in which the IOM recommended that “*The National Council of State Boards of Nursing (NCSBN), in consultation with patient safety experts and health care leaders, should undertake an initiative to design uniform processes across states for better distinguishing human errors from willful negligence and intentional misconduct, along with guidelines for their applicability by state boards of nursing and other state regulatory bodies having authority over nursing.*” (Institute of Medicine, 2004).

To systematically track and evaluate the causes of adverse events from both individual and system perspectives, and enable the development of proactive interventions to protect patient health and safety, NCSBN initiated the Taxonomy of Error Root Cause Analysis of Practice-responsibility (TERCAP®) project. Practice breakdown is defined as the disruption or absence of any of the aspects of good nursing practice and the term “practice breakdown” is used in this context because it broadens the categorization of events reported to TERCAP®.

The TERCAP® database, developed in 2007 in consultation with nursing regulators, researchers, and educators nationwide, is a direct response to the IOM’s concerns. It is designed for boards of nursing (BONs) to collect standardized, comprehensive and consistent information regarding nursing practice breakdown during investigations and report practice breakdown cases to NCSBN for analysis of error trends.

Based on 3,075 practice breakdown cases submitted by 25 BONs, NCSBN completed the 2014 TERCAP® report, which examined all components involved in the TERCAP® model by evaluating the contributing factors associated with practice breakdown from nurses’, patients’, and system perspectives. Figure 1 shows the BONs that have contributed data to TERCAP®.

Figure 1. BONs contributing to TERCAP ®



(TERCAP continued from page 2)

HIGHLIGHTS OF THE 2014 TERCAP® REPORT

Nature of Practice Breakdown and Contributing System Factors

- 73 % of the practice breakdown cases submitted to TERCAP® involved unintentional errors.
- While 56 % of the practice breakdown did not cause harm, 44 percent did cause harm to patients.
- The most frequently reported practice breakdown categories include a lack of professional responsibility and/or patient advocacy, defined as a nurse failing to act responsibly in protecting patient vulnerabilities (73 %), lack of clinical reasoning (49 %), and lack of intervention (48 %).
- Miscommunication (38 %) and health care team conflicts (39 %) were the most frequently reported system factors contributing to practice breakdown.

Characteristics of Patients and Practice Breakdown

- 66 % of the patients involved in a practice breakdown were 50 years or older.
- Patients 65 years or older are more likely to be affected by lack of intervention compared to patients 18 years of age or younger (56 % versus 39 %).

At the time of the practice breakdown, 62 % of patients up to 18 years of age were accompanied by their family or friends, while only 22 % of patients aged 65 and above were accompanied by family or friends.

Characteristics of Nurses Contributed to Practice Breakdown

In line with previous NCSBN studies (E. H. Zhong, Kenward, Sheets, Doherty, & Gross, 2009; E.H. Zhong & Thomas, 2012), the 2014 TERCAP® report showed that nurses with a previous negative job history (discipline or termination for practice issues by employers) or discipline were more likely to commit practice breakdown. In addition, male nurses and licensed practical nurse (LPNs) or vocational nurses (VNs) are over represented in the group of nurses who committed practice breakdown.

- 38 % of the nurses had been previously disciplined by their employers for practice issues.
- 9 % of the nurses had been disciplined by BONs before the current incident, while the average annual discipline rate by BONs in the general nursing workforce is less than 0.3 %.
- 5 % of the nurses had a criminal conviction history while less than 3 % of the non-disciplined nurses had such a history.
- 15 % of the nurses were male, compared to 9 % of the national nursing workforce.
- 37 % of the nurses held LPN/VN licenses, compared to 20 % of the nursing workforce.

The Initial Trend Reviews (2008-2014)

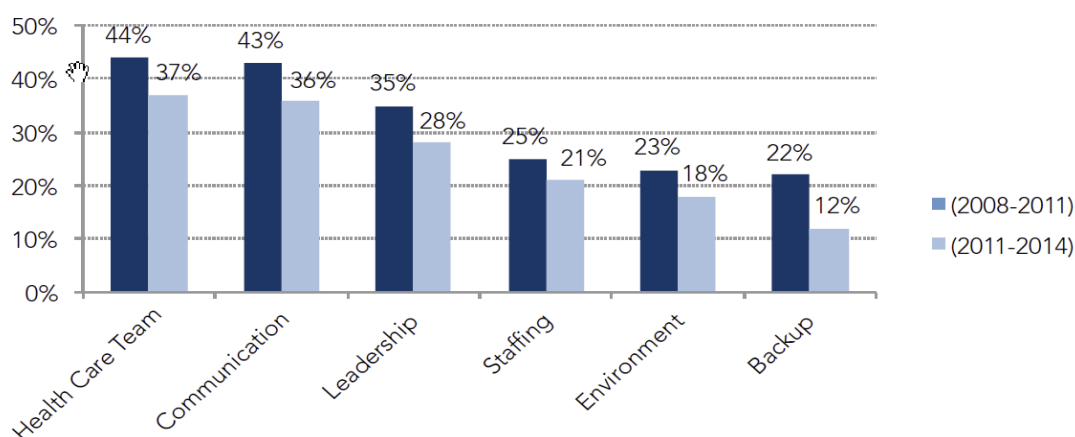
The proportion of types of practice breakdown reported to TERCAP® remained consistent over the past seven years. There was a slight decrease in the proportion of cases related to a lack of professional responsibility and/or patient

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advocacy from the 2008-2011 reporting period (78 %) compared to the 2011-2014 reporting period (71 %), and a slight increase in cases related to a lack of prevention, from 23 % to 29 %.

There was a slight decrease in the proportion of cases involving system factors reported to TERCAP® since 2011 (Figure 2). This positive tendency could be a result of a group effort from BONs and other health care members in improving the health care system.

Figure 2. Proportion of Cases Involving System Factors Reported during 2008-2011 and 2011-2014



Facility Issues

The current report examined the distribution of registered nurses (RNs) and LPN/VNs by employment setting compared to the national composition. At the time of practice breakdown, 16 % of RNs and 56 % LPN/VNs worked in long-term care (LTC) facilities, while the Health Resources and Services Administration (HRSA) U.S. Nursing Workforce report showed that nationally only 7 % of RNs and 31 % of LPN/VNs worked in nursing care facilities (HRSA, 2013). Conversely, 52 % of RNs and 8 % of LPN/VNs worked in hospital settings when the practice breakdown occurred; however, nationally, 63 % of RNs and 29 % of LPN/VNs worked in hospital settings (HRSA, 2013). The underlying causes for higher reporting of practice breakdown in LTC facilities compared to hospital settings are unclear. A further analysis on the cases reported from LTC facilities and hospitals showed the following:

- 85 % of LTC nurses versus 3 % of the hospital nurses were assigned more than 10 direct care patients.
- 80 % of the LTC patients and 37 % of the hospital patients were 65 years or older.
- 67 % of the LTC facilities versus 20 % of hospitals used paper documentation record systems.
- 28 % of the LTC cases versus 17 % hospital cases claimed that a staffing issue contributed to the practice breakdown.
- 32 % of the LTC cases versus 25 % of the hospital cases reported that leadership contributed to the practice breakdown.
- After BON investigations, 14 % of the LTC cases versus 10 % of the hospital cases were dismissed by BONs

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- 49 % of the LTC cases versus 57 % of the cases from hospitals resulted in disciplinary action by BONs.

Summary

The proportions and types of practice breakdown reported to TERCAP® remained consistent over the past seven years. Unintentional errors were the predominant cause (73 %) of cases submitted to TERCAP, with less than half of the reported breakdowns involving harm to patients. Practice breakdowns occurred more frequently in LTC facilities, as compared with hospitals, and involved older patients at a higher frequency than younger patients. The TERCAP® data supports existing evidence that nurses with a history of disciplinary action or reported violation experienced more practice breakdowns, particularly in male nurse and LPN/VN populations.

Future Plans

NCSBN will continue the TERCAP® data collection and further promote the TERCAP® project at the state and national levels with the goal to increase participation of all BONs. NCSBN will monitor the possible trend changes after the implementation of the Affordable Care Act within a two-year time frame.

With the establishment and refinement of the TERCAP® database, along with the release of the 2011, 2013 and 2014 TERCAP® reports, NCSBN has fulfilled the IOM request of designing uniform processes for BONs to follow. With broader participation from BONs, additional analysis can be performed to further investigate the causes of practice breakdown and move the TERCAP® project to the next level - development of rational strategies to prevent and reduce practice breakdown.

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(President's Message continued from page 1)

APRN Compact in Minnesota would require approval by the Minnesota legislature. Consideration of NLC in the past has not been without concern in Minnesota. Consideration of the new NLC will require active engagement of nursing and other stakeholders across our state to determine the best direction for Minnesota.

On a different note, I want to formally acknowledge the work and effort of Board members whose terms ended this year: Julie Riportella, LPN, Diane Scott, RN and Monica Parks, RN. I am grateful for their contributions and the thoughtful and thorough considerations they brought to their service. I also wish to extend my congratulations to Michelle Harker and Chris Norton who were re-appointed to the Board as public members. And I wish to welcome new Board member appointees, Brad Haugen, RN; Robert Muster, RN; and Becky Gladis, LPN.

Minnesota's Prescription Monitoring Program

Minnesota is one of 49 states that currently have an operational Prescription Monitoring Program (PMP). The MN PMP, which is administered by the MN Board of Pharmacy, has been operational since January 2010 and continues to collect an average of 8 million controlled substance prescription records annually.

In 2014 alone, more than 800,000 queries to patient profiles were requested by more than 13,000 prescribers and pharmacists who have been granted direct access to the MN PMP database. There are more than 25,000 Minnesota prescribers and pharmacists permitted by law to have direct access to the MN PMP database to view patients' controlled substance prescription profiles. Currently 1,335 of the 6,340 Advanced Practice Registered Nurses (APRN) licensed in Minnesota, who have the authority to prescribe controlled substances, have applied for and been granted direct access. APRNs who are authorized to prescribe controlled substances may apply for access to the MN PMP database by completing an online access request form. Once the information has been submitted electronically, MN PMP staff will review the application and approval notifications will be sent via email within two business days. Access Request Forms can be found on the MN PMP website at www.pmp.pharmacy.state.mn.us

PMP registration and access are free. Prescribers may access the PMP database 24 hours a day, seven days a week. Prescribers themselves or their employers may decide how often and when they will request patient profiles. Some may decide to do so for all patients for whom the prescribing of a controlled substance is being considered. Others may do so only when they suspect potential abuse. The reports can be used to determine appropriate medical treatment such as referral to a pain-management specialist as well as to identify "doctor-shopping" behaviors. The PMP encourages prescribers and pharmacists to assist individuals tentatively identified as having an issue of concern regarding controlled substances in finding the help they need.

Prescribers, pharmacists and delegates must respect confidentiality, and may only access data on those patients for whom they are directly providing care. Patient profile reports from the MN PMP database are designated as private data and can be used to supplement an evaluation of a patient, confirm a patient's drug history or document compliance with a therapeutic regimen. However, the MN PMP does not warrant any patient profile to be accurate or complete, as it cannot guarantee that dispensers have accurately reported all controlled substance prescriptions that they have dispensed. In addition to checking on a patient's controlled substance prescription history, a prescriber with an active MN PMP user account has the ability to view a report of the controlled substance prescriptions dispensed using their DEA registration number. This functionality enables the prescriber to monitor use of their DEA registration number and to potentially detect fraudulent use.

More information about MN PMP is available at pmp.pharmacy.state.mn.us . PMP staff are:

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Melissa Winger, PMP Coordinator
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Reporting to the Board of Nursing

One of the main responsibilities of the Board of Nursing is to ensure that nurses comply with the Minnesota Nurse Practice Act and to investigate and resolve complaints filed against nurses. The Board receives complaints from a variety of sources, including employers, patients or a patient's family member, licensed health professionals and other State agencies.

Who Should Report?

Any person who has knowledge of conduct by an advanced practice registered nurse, registered nurse, or licensed practical nurse that may be a violation of a nursing law or rule or related state or federal law may report the alleged violation to the Board of Nursing.

Some persons, such as employers, are required to make reports, under specific circumstances.

The **Chief Nursing Executive or Chief Administrative Officer** of any health care institution or organization in Minnesota is *required* to report:

- Disciplinary action taken by the institution or organization if the basis for the employment action pertains to the Board's grounds for disciplinary action
 - A report must still be made if a nurse resigns before conclusion of any disciplinary proceeding or in lieu of discipline.
- ***A Note About Impaired Professionals.*** Minnesota law provides for the Health Professionals Services Program ("HPSP"), a non-disciplinary monitoring program for health professionals, including nurses, whose ability to practice may be impaired by mental or physical health or substance use disorder. A report to the HPSP fulfills the mandatory reporting obligation of employers, in applicable circumstances. An employer must report diversion of controlled substances to the applicable board, as described more fully in the previous edition of this newsletter.

Persons licensed by any Minnesota health regulatory board including nurses, physicians, pharmacists, nursing home administrators, and social workers are also *required* to report:

- Personal knowledge of a nurse's conduct reasonably believed to be grounds for disciplinary action by the Board.

Note: The reporting of professional knowledge obtained in the course of a health professional-client relationship when the client is a nurse and the health professional successfully counsels the nurse to limit or withdraw from practice to the extent required by the impairment is excluded from this requirement.

In addition, there are circumstances under which **Insurers** and **Court Administrators** are required to report to the Board. **(Reporting to the Board continued on page 9)**

APRN Certification Renewal Reminder

To maintain an APRN license in Minnesota an APRN must have on file with the Board of Nursing:

- A current Minnesota RN license; and
- Current certification as an APRN in the role and focus for which the individual is licensed.

The Board will email licensed APRNs whose certification is due to expire within the next 90 days a reminder to have the verification of recertification sent directly from the certifying organization to the Board upon renewal. The verification of certification must:

- be sent directly to the Board from the national nursing certification organization that certifies you in an APRN role and population
- may NOT be a copy of the certification sent by the APRN
- must be sent to the Board of Nursing directly from the certifying organization EACH time the APRN renews certification

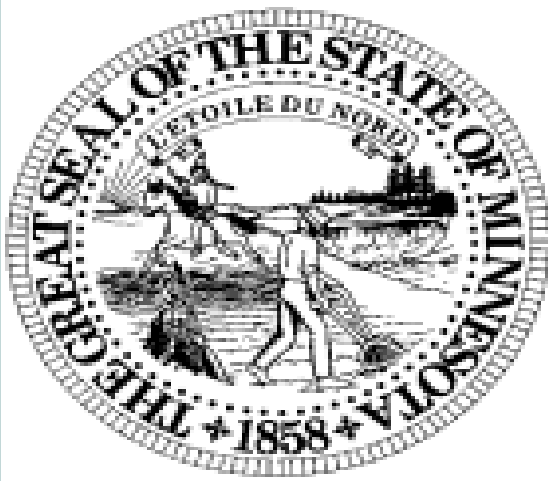
If the Board does not have verification of **current** certification on file, the APRN license will expire, and the APRN will not be authorized to practice an APRN in Minnesota. Further, if the APRN practices after the expiration of the license, there may be associated penalties.

Journal of Nursing Regulation

Journal of Nursing Regulation (JNR), the official journal of the National Council of State Boards of Nursing (NCSBN®), is a quarterly, peer-reviewed, academic and professional journal. It publishes scholarly articles that advance the science of nursing regulation, promote the mission and vision of NCSBN, and enhance communication and collaboration among nurse regulators, educators, practitioners, and the scientific community. The journal supports evidence-based regulation, addresses issues related to patient safety, and highlights current nursing regulatory issues, programs, and projects in both the United States and the international community. In publishing *JNR*, NCSBN's goal is to develop and share knowledge related to nursing and other healthcare regulation across continents and to promote a greater awareness of regulatory issues among all nurses.

The *Journal of Nursing Regulation* will now be published by Elsevier. There will be no difference in the editorial portion of the journal. This change will enhance global visibility and access to the journal. To access the journal, follow the link <http://www.journalnursingregulation.com/#>





Minnesota Board of Nursing

Link to Board member profiles:

<http://mn.gov/health-licensing-boards/nursing/about-us/about-the-board/current-board-members.jsp>

How to become a Board member:

<http://mn.gov/health-licensing-boards/nursing/about-us/about-the-board/current-board-members.jsp>

Minnesota Board of Nursing Members

Board Member Name	Board Role
Cindy DeJarlais	LPN Member
Jeanine Gangeness	RN Member
Becky Gladis	LPN Member
Deborah Haagenson	RN Member, Board President
Michelle Harker	Public Member
Bradley Haugen	RN Member
June McLachlan	RN Member
Deborah Meyer	LPN member, Board secretary
Robert Muster	RN Member
Christine Norton	Public Member
Jan Rainey	Public Member
Christine Renne	Public Member
Sheila Robley	LPN Member
Sue Sendelbach	RN Member, Board Vice President
Steven Strand	RN Member
Natya Stroud	RN Member

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More information about the laws and rules regarding reporting obligations are located in [Minnesota Statutes Section 148.263](#) and [Minnesota Rules Part 6321.0500](#).

What Should Be Reported?

The Minnesota Nurse Practice Act currently includes 28 grounds for disciplinary action by the Board, addressing a range of concerning behaviors. The grounds can be generally categorized into concerns regarding conduct that is unsafe or incompetent practice, unethical, illegal, affected by the use of drugs, alcohol, chemicals or a mental or physical condition or other violation of state or federal laws.

The Board encourages employers to evaluate the nurse's conduct and behavior in determining whether a nurse is unsafe or incompetent and, therefore should be reported to the Board. It is important to look beyond the outcome to the patient or resident. A incident involving poor judgment or risky behavior may result in no actual patient harm but represent a more significant concern for competence than a single human error that unfortunately reaches the patient. The latter may more appropriately be addressed within the facility by examining the human and systems factors resulting in the error. A complaint registration form and additional information regarding the Board's complaint review process may be found on the Board's website: <http://mn.gov/health-licensing-boards/nursing/public/complaints/>